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ABSTRACT

This document summarizes the discussion and reports of a workshop on continuing education of health personnel in Europe. The document is organized in six sections. The first section introduces the challenge of health personnel training and its relevance to health needs. The second section summarizes the major characteristics and general trends in continuing education systems in Europe and reviews country surveys that cover the basic issues. It also provides a general account on policies, existing structures, conditions, problems, and future trends of continuing education systems. In the third section, innovative approaches for the continuing education of health personnel are summarized, and 10 case studies of innovative approaches are reviewed. Section 4 presents a discussion of key issues in continuing education, such as the role of continuing education in primary health care, adapting to change, evaluation and a systems approach, interprofessional team building, and obstacles to change through continuing education. The final two brief sections draw conclusions from the case studies and make recommendations for providers and users of continuing education. A list of working papers and background material and list of participants are included in the report. (KC)

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TARGET 36

Planning, education and use of health personnel for health for all

Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.

Index:

EDUCATION, CONTINUING
HEALTH MANPOWER
PRIMARY HEALTH CARE
HEALTH FOR ALL
EUR

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1. Introduction

Health personnel training and its relevance to health needs is considered as one of the most important topics in the activities of WHO. Most of the health professionals, who will be practising in the year 2000 and later, have already completed their studies. Continuing education (CE) is therefore an essential prerequisite to allow practising health professionals to improve their attitudes and competences in order to bring their work more closely into line with the changing health needs of the population.

The WHO as a whole, and the Regional Office for Europe in particular, have organized several meetings and published several documents dealing with CE systems and with selected priority aspects of CE. The identification of priority problems and approaches to make CE more efficient and effective were evolved in recent years as a continuous process.

The major challenge for CE of health personnel was posed in 1977, when all Member States accepted the strategy for Health for All (HFA) by the Year 2000. The European Region has taken important steps towards the attainment of that goal. The Regional Committee adopted for the first time ever a broad policy for the whole Region in 1980. This decision was followed in 1984, when the Regional Committee took another big step forward and decided that this regional health policy should be strengthened by the adoption of the 38 regional targets.

Target 36 called for action to ensure that planning, training and use of health personnel would be in accordance with HFA policies, with emphasis on the primary health care (PHC) approach. Consequently, the regional programme for health manpower development placed emphasis on effective and economical use of health personnel through appropriate CE systems, teamwork and personnel management practices.

This process was, as a matter of fact, already initiated in 1973 at the Expert Committee meeting on "Continuing Education for Physicians", Geneva. In the European Region, the issues of continuing education for health personnel and its evaluation, were the subject of the technical discussions at the 29th Regional Committee meeting, Helsinki, 1979, where specific recommendations were proposed for the future organizational planning of CE in the Region.

A new impetus was given by the Consultation on Continuing Education and Multiprofessional Training, Copenhagen, October-November, 1984, as an expression of the intention of the Regional Office to provide support for Member States in the organization and methodology of CE of health personnel, especially in PHC in relation to the changing national needs and policies.

As a follow-up to the Consultation, a "Study on systems and organization of CE at country level" was organized in 1985-1987, with a view to accumulate evidence on the feasibility and potential efficiency of CE programmes for PHC teams. During the first phase of the study in 1985-1986 the information was collected on the existing situation and tendencies concerning CE activities in eight countries of the European Region, with particular reference to CE programmes for PHC teams. The findings of these initial surveys were presented and discussed at the meeting convened in Copenhagen, April 1986. The results indicated that CE can be an important instrument towards integration between the health services and manpower development (HSMD), leading to the gradual achievement of the regional PHC targets.

As an outcome of the meeting, during the second phase of the "study on systems and organization of continuing education at country level", case studies were designed and carried out in 1986-1987 in eight selected European countries. They were aimed at providing evidence and identification of the prerequisites and circumstances leading to the success or failure of CE programmes for members of PHC teams, as well as to indicate the impact of specific CE programmes on the quality of health care. In addition, further surveys were carried out in other countries of the European Region, so that initial surveys from 19 countries were available for the Workshop to promote the use of new methods in continuing education, which was held in Barcelona from 9 to 12 December 1987.

In the light of the above activities the Workshop set out to examine the outcome of both the surveys and the case studies and to identify ways and means to develop systems and programmes of continuing education of health professionals promoting innovative methods which will take into account changing national health needs, as well as HFA policies, and lay emphasis on PHC.

The more detailed objectives of the Workshop were:

1. Analysis of effectiveness, efficiency and relevance of the case studies describing specific and concrete situations in CE activities for PHC team members at national/regional or institutional levels. The analysis was based on criteria formulated in the protocol for preparation of case studies.

2. On the basis of the analysis of the case studies to formulate appropriate conditions and necessary resources for further development of CE programmes for PHC personnel.

3. Suggestions and recommendations for implementation of strategies and continuous operation of CE systems and programmes, which would make a valuable contribution towards the attainment of HFA 2000 with emphasis on PHC.

The Workshop was attended by the twenty-three country investigators, who had prepared the initial surveys and the case studies. Also present were, one representative from the Commission of the European Community, three from the Ministry of Health and Consumer Affairs, Madrid, two observers from the Institute of Health Studies, Barcelona, and four staff members from WHO Headquarters and the European Regional Office (Annex II, List of participants).The working papers consisted of nineteen initial surveys and ten case studies; three background documents were also made available. A short review of country reports was prepared by the coordinator (Annex I, List of working papers and background material).

The Workshop was opened by Dr J.Raventos Conti as representative for the Spanish Ministry of Health in Catalonia, and Dr J.-P. Menu, Regional Officer for Health Manpower Development (Management), at the WHO Regional Office for Europe on behalf of the Regional Director, Dr J.E. Asvall. Dr Menu emphasized recent developments in the achievement of the strategy and targets relating to the goal of HFA 2000 in the European Region. He stated that clear policies on the reorientation of planning, training and use of health personnel in accordance with HFA strategy were essential at this stage of development. He underlined that CE systems had an important role to play, particularly as an agent for change of the attitudes of PHC team members.

Dr V. Vodoratski, Regional Officer for Health Manpower Development (Education), WHO Regional Office for Europe, who was the Technical Secretary of the workshop, made an introduction to the Workshop's objectives and methods of work.

Professor A. Oriol-Bosch was elected Chairman with Professor A. Wojtczak as Co-Chairman. Professors Ch. Engel and J. Vysohlid were elected Rapporteurs.

The discussions took place in plenary sessions and in three groups.

2. Major characteristics and general trends in CE systems in the European Region (review of country surveys)

This is the first time that current, and to some extent standardized, information has been collected on systems of CE of health personnel in the European Region by means of the initial surveys on continuing education systems at country level, which were undertaken in two phases. In the first phase eight reports were prepared in France, Hungary, Italy, Spain, Sweden, Union of the Soviet Socialistic Republic, United Kingdom and Yugoslavia. These country reports were presented at the meeting in Copenhagen in April 1986, where it was recommended that further reports be assembled about other countries. At the time of the Workshop another eleven surveys were available from Bulgaria, Czechoslovakia, Denmark, German Democratic Republic, Greece, Finland, Israel, Netherlands, Poland, Portugal and Turkey. A new review on recent developments in Spain (National Health Act, 1986) was prepared to complete the description submitted in 1986.

The reports followed the identical guidelines. The reports cover the basic issues and a general account on policies, existing structures, conditions, problems and future trends of the CE systems. The reports made considerable contributions to the information on systems of CE for health personnel in the European Region. However, it was recognized that the reports could not convey a truly comprehensive account for the whole of each country. The reports were usually compiled by a single investigator, assisted in some instances by a small group of collaborators. The authors and titles of all the country reports are given in Annex I. A short review of these reports was prepared in order to facilitate the discussions (see Annex I).

The following summary of major characteristics and general trends should not be seen as a precise analysis. In view of the variety of issues and problems described within widely differing contexts, only an informal approximation could be presented here.

2.1 Characteristics of health systems

The relationship between CE systems and systems of health services was seen as vital. There was a clear tendency for the state to assume major responsibility for the provision of health care. However, the state health services were organized and structured quite differently in each country. Most health services systems were organized either as national health services or as socialist health services, with more or less well developed decentralized structures. A few countries had a pluralistic system. In one country the health system was based on decentralization and self-management, and another country operated a system of private health services with insurance coverage for the majority of the population.

2.2 Process of health manpower development in relation to health services

There were different levels of development with regard to health manpower or health services manpower development (HSMD). In one-half of the countries in the survey, the process of planning, training and management of health personnel in meeting the needs of the health services was more highly developed and covered at least the essential aspects of HSMD. In approximately one-half of the countries the HSMD process dealt with only some aspects of HSMD or was in a stage of development. For the remaining countries, the reports indicated no regulated pattern of HMD within the health services system.

2.3 Continuing education with particular attention to PHC

A system of CE for health personnel existed in all countries under review, but the level of development varied. Some countries had a system of CE with a structure at all three levels: central, regional, local. In other countries, the CE systems operated primarily at the regional/provincial and local level. Various institutions or organizations had been created to further the planning, provision, management and evaluation of decentralized CE systems.

It was interesting to observe that CE for members of PHC teams had become recognized as a priority in all countries. Even so, important differences in the level of development of CE for PHC personnel were identified. In those countries where the PHC services were highly developed, CE activities were also regular and systematic. However, in nearly half the countries under review, the level of development was relatively low, in the process of development, or not yet developed.

2.4 Providers, participants and teachers involved in continuing education

In the majority of cases the State was the main provider of CE activities, including CE for PHC personnel in particular. It appeared that there was a growing tendency towards decentralization to regional and local levels. In a smaller group of countries a pluralistic system accommodated different providers, including local government or county councils, independent health organizations, professional associations, trade unions, as well as private establishments. In most countries, the main providers cooperated with other partners, particularly with universities, medical schools, schools of public health, regional/teaching hospitals and professional non-governmental organizations.

The main category of participants in CE were physicians, but in a number of countries there was a tendency for an increasing number of nurses and other health professionals to participate in CE. CE programmes increasingly tended to address a multiprofessional audience, although this was not yet so in the majority of programmes. Mandatory participation existed either for all CE programmes, or only for some especially selected ones. As an increasing number of CE programmes came to be provided by the health authorities, mandatory attendance appeared to be required in more countries than before. Participation in CE programmes continued to be entirely voluntary in one third of the countries.

The relationship of teachers/instructors to the providers of CE varied according to the type of provider. Where CE programmes were implemented at central/regional/county level, the teachers tended to come from medical schools, institutions for postgraduate education or were heads of departments in teaching/regional hospitals. Locally or community-based CE programmes tended to be staffed increasingly by general practitioners and other professionals at the PHC level.

2.5 Methods of CE

It was observed that CE programmes tended to provide increasing opportunities for active participation and interpersonal contact, including self-directed-learning and self-assessment . However, these innovations were exceptions rather than the rule. In general, CE was offered as courses from one to several days/weeks duration, organized either in educational institutions, hospitals, policlinics, or at the participants own place of work. Methods usually included lectures with case demonstration, seminars, workshops and audiovisual aids. Handouts, bibliographies and guidelines for self-directed-learning, and computer-based learning were an exception.

2.6 Impact and outcome of CE

The evaluation of the effectiveness and efficiency of CE programmes was one of the weakest aspects. The main problem appeared to lie in the absence of methods based on reliable studies and research. However, attempts were being made in several places to evaluate CE programmes at least for gain in knowledge and, sometimes gain in skills. The problem of assessment of the impact of CE programmes on the quality of health care had not yet been solved.

2.7 Future trends, especially with regard to HFA 2000 strategy

The surveys clearly showed a tendency to orientate the CE systems to the European strategy of HFA in general and to continuing education for members of PHC teams in particular. It is noteworthy, that national documents on the strategy for achieving HFA targets paid due attention to the further development of CE programmes for PHC members.
Some countries were about to analyse the existing situation, future needs and expected outcomes of both the health services system and CE activities and programmes. Such initiatives could lead to substantial changes in the relevance of CE programmes to health care and PHC needs.

3. Innovative approaches for CE of PHC personnel within the framework of HFA 2000 strategy (Review of case studies)

In accordance with the recommendation made at the meeting in Copenhagen, April 1986, six case studies on innovative approaches for continuing education of primary health care personnel within the framework of HFA 2000 strategy were prepared in France, Hungary, Italy, Spain, Sweden and Yugoslavia; and four case studies were submitted from the Union of Soviet Socialist Republics (2) and from the United Kingdom (2), respectively (Annex I).

A case study, by definition, is a detailed study of a single, well defined event. The present case studies respectively described events in a particular geographical area or in a particular health care setting. Each dealt with a specific target group, using a particular approach to CE. For this reason, it has been necessary to review each case study separately,

although the description of courses followed an agreed protocol (Report of a WHO Meeting on Study on Systems and Organization of Continuing Education at Country Level, Copenhagen, 22-24 April 1986, p.8, Item 5.3 and p.9-10, Item 5.5 refers), and there was thus some similarity in presentation.

3.1 Continuing education for primary health care teams in local hospitals (case study from France, by Dr P. Klotz)

In this case study, local hospitals (formerly "rural hospitals") represented components of the public hospital system. They were open to all general practitioners for treating their own patients. These local hospitals were involved in PHC activities.

As a local initiative, an analysis was made to assess problems of health care provision in these hospitals. The analysis resulted in a plan to improve health care delivered in local hospitals using decentralized refresher courses and sessions within these hospitals. The aim was to increase and refresh knowledge, skills and attitudes through an exchange of experiences among physicians, nurses and managers.

Those who participated in planning the programme were the representatives of the local associations for Continuing Medical Education (CME), general practitioners, managers, nurses, medical advisors from social security, as well as from local and major hospitals in the area.

Eleven local hospitals of a district agreed to meet every two months for educational sessions, each time in a different hospital. A list of educational needs was prepared with active participation of the delegates from these hospitals. Costs were covered by the CME association (organization, travel for resource persons) and by the participants (travel and meals). There were no tuition fees, and participation was voluntary.

Participants were general practitioners, nurses, directors of local hospitals and other staff (e.g., cooks). Sessions started in the afternoon and lasted for 5-6 hours (with dinner). Small group discussions on actual cases of patients was the main method. Resource persons were local doctors, dietitians, psychologists and other health professionals.

A formal assessment of impact and practical consequences was not undertaken at the time, but actual change in the provision of care was achieved in at least two aspects: physicians became more concerned with meals served to patients, nurses became aware of possible misuse and carelessness in the administration of sleeping drugs.

3.2 Continuing education model for doctors, leaders and managers working in health administration and responsible for local HFA policy (case study from Hungary, by Professor I. Forgacs)

A need was identified to enhance leadership for the implementation of the national HFA policy. The main aim was to adapt and strengthen CE training of health personnel in health administration and for local implementation of the national HFA policy and PHC.

The plan was to produce a specific course within a three-year specialty training period in public health management and social medicine for doctors.

The participants were chief medical officers, directors of hospitals and their deputies, medical officers, managers in health administration and health education and junior staff members of departments of social medicine in various educational institutions.

The training model was a 20-day course (usually seven hours a day), with lectures in plenary sessions and discussion in small groups. Teachers came from among the staff of the institute of social medicine.

Evaluation of new knowledge and skills was assessed by MCQ test. This test was mainly for self-assessment. The participants provided positive feedback by questionnaire with regard to the relevance, importance, context and format of the course.

3.3 Specific strategies and programmes in CE for health managers, medical specialists, generalists and nurses carried out in selected regions (case study from Italy, by Professor B. Paccagnella)

The main aim was to initiate an active involvement of the Regions in creating CE programmes with specific objectives to change the pattern of CE and to support development strategies on a larger scale.

In planning this programme different initiatives and approaches were used, e.g., creation of a Scientific Committee (regional government together with non-governmental agency) proposing and implementing CE for managers; establishment of a regional institute for CE; appointment of "working groups" to plan and implement CE initiatives; programmes for general practitioners and paediatricians, prepared in agreement with regional governments and medical "orders" and medical trade unions.

Participation in CE for managers included several categories of health personnel, e.g., managers of medical services (including PHC), nursing, social and administrative services, specialists, general practitioners and paediatricians, nurses from hospitals, and nurses, social workers and health visitors from PHC participate in CE. Moderators for CE of general practitioners were trained in medical pedagogy and communication techniques.

While methods of CE differed according to the objectives and the type of participants, seminars, workshops and small groups were normally used. Programmes for managers were based on modules and sequences of modules, where participants could choose examples and exercises for the working groups and work in small groups with self-learning tasks; for the general practitioners and administrators case simulation and role playing were being introduced.

Evaluation had been performed by participants expressing their subjective assessment on context and educational methods.

3.4 Evaluation of the impact of a continuing education course for PHC personnel (case study from Catalonia, Spain, by Drs Martinez-Carretero, Maria Nolla Domenjo and Professor A. Oriol-Bosch

A basic course for PHC personnel (BC-PHC) had been administered for three years, and it was decided to evaluate the course's mid- and long-term impact on the provision of care to the community. Evaluation was to identify

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how many of the activities judged essential to PHC were actually being undertaken by the doctors and nurses.

A questionnaire was mailed to all doctors and nurses at least 6 months after completion of the BC-PHC. 536 questionnaires were mailed; 162 doctors (44%) and 137 nurses (42%), i.e., a total of 299 (56% of those administered) responded.

Participants were doctors and nurses active in PHC and willing to be engaged in the PHC reform. Attendance was a prerequisite for participation in other PHC training (i.e., specific units on selected topics). Teachers were chosen from professionals active at the PHC level and were given a training course in educational methods.

Active group dynamics were employed as the main teaching/learning method.

Results of evaluation can be summarized as follows:

The impact of the BC-PHC was considered higher by the nurses (73%) than by the doctors (59%). The impact was different for each activity and was differently assessed by doctors and nurses. The impact was considered important by over 80% of those who stated that they carried out a particular PHC activity. The course was considered useful in gaining knowledge, skills and attitudes relevant to daily PHC work. Improvements were acknowledged in knowledge, motivation towards daily duties, exchange of experiences, teamwork overcoming professional isolation. There were some legal, structural and organizational obstacles which were being changed in order to make better use of new knowledge, skills and attitudes in PHC practice.

3.5 CE for the role of PHC in the care of the elderly (case study from Sweden, by Mr B. Eklundh, Mr J. Hultin, Dr B. Mattson and Dr Margerata Troein

The main purpose was to enable PHC personnel to cope with ongoing changes in the care of the elderly: diminishing institutional and enhancing out-patient and home care.

CE was to improve knowledge and skills in selected aspects; influence the attitudes of health workers and through them the municipalities; increase readiness to take initiatives and improve cooperation among health workers.

The responsible body for planning CE activities was a newly established permanent group of experts in the field of general medicine under the Committee of Postgraduate Education of the National Board of Health and Welfare. Six courses were approved under the leadership of a district physician and a district nurse who worked together at a health centre. They were briefed during a two-day meeting. Psychiatrists and physiotherapists acted as resource persons. Important contributions in the teaching were made by the participants themselves.

The participants were a team of doctors and nurses from the same health centre; in some instances a responsible person from the social service office was also present.

The course lasted five days. The participants stayed in the same

hotel with provision for social interraction: long lunch breaks and evening discussions. Lectures, group work, case studies, role play, workshops and films were used.

Short-term evaluation was performed by questionnaire on an overall judgement of the course; long-term evaluation was made by questionnaire with five statements on the course and its outcome in relation to actual practice. Outcomes were greater understanding and increased knowledge in the care of the elderly; innovations and changes initiated by the participants for the care of the elderly.

3.6 Education for health through primary health care (health education authority/Open University) (case study from UK by Dr D.M.D. Lambert)

The main aim was to produce distance learning programmes for PHC teams in cooperation with the Open University and the health authority.

The programmes were to improve and encourage teamwork and understanding of professional roles; communication between professionals, as well as between professionals and clients or patients; communication with the community and enhanced participation by members of the community in planning their own health care.

The distance learning material was designed by a team of general practitioners, nurses, educational experts, consultants in specific subjects, other PHC professionals. Individual study packs contained a workbook, activity booklet, a book and an audiotape. The group work-pack consisted of a full individual pack with a videotape and a set of group leader's notes.

Information about the distance learning programmes was distributed through the Open University regional network; through printed materials and newsletters, as well as through health professional networks. The CE activities consisted of self-learning with prepared distance learning material and workshops organized as two-day residential events. Workshops were planned jointly between the health authority, postgraduate regional advisers in general practice and the regional or district health authority.

Participants in distance learning were professionals working in PHC. In the workshops general practitioners and practice or community nurses were intermittantly joined by health education officers, community physicians and family practice committee administrators.

Teachers were the participants themselves, working together with course organizers.

The distance learning materials were assessed in the short term by measures of uptake and feedback from group work facilitators. It is intended to invite the same participants to attend a review day after one year, in order to assess the implementation of practice plans prepared within the CE activity. In the meantime, each practice was to be visited by the workshop organizers.

3.7 CE for PHC physicians in a large industrial town provided through "mobile courses" (case study by the Central Institute for Advanced Medical Studies, USSR)

The reason for these CE activities was, that in a big town without an

institute for advanced medical studies, courses held away from the city and requiring long absences from work are not entirely satisfactory. CE courses for PHC physicians were, therefore, held in the town through "mobile training courses" organized by the central educational institution.

The aim was to provide CE for the city's PHC physicians with due regard for local conditions and needs.

Experience was accumulated over 24 years (1961-1984) with 90 "mobile training courses", attended by more than 2500 participants. 5-year plans were prepared in close collaboration between the providers and the city health authority. Annual plans were adjusted with due regard to available logistic support, training facilities, local pathology trends and groups of participants. Analyses of trends in morbidity and mortality, as well as performance of HS, served as a basis for planning and organization.

Mobile teams of teachers from the central institution provided the courses for PHC doctors who could attend regularly every five years.

Forms and methods of the course: 6-8 weeks courses with a daily programme: 9 a.m. - 3 p.m. - morning conferences, rounds, consultation, demonstrations, out-patient examination, lectures, laboratory exercises; 5 p.m. - 7 p.m. - lectures, seminars, discussions, sessions of professional societies.

Topics were orientated mostly to out-patient care: first aid and emergency cardiology, gastroenterology for general practitioners; infectious diseases and resuscitation of children for paediatricians; abnormalities and prevention in pregnancy for gynaecologists and obstetricians; effectiveness of in- and out-patient services for PH administrators.

While it is a tendency to evaluate outcome of CE for improved quality of HC provided by the participants, improvement does not solely depend on CE activities but is related to a broader "natural" development of health care in all its components. A model for efficiency criteria was worked out. Qualitative indicators were surveyed with local general practitioners and paediatricians through evaluation of case histories and out-patient cards by an expert . For control purposes the findings from the case histories, filled in by the same physicians before the training course, were used. Main criteria for the local general practitioners were early detection of changes in health status, appropiate screening and health promotion activities; for the paediatricians the criteria were regular check ups for healthy children, appropriate preventive activities, follow-up of risk groups, promotion of rational nutrition and its correction. The data obtained were processed statistically and were positive.

3.8 Experiment to establish effective methods for CE of PHC personnel in prevention of non-communicable diseases (case study by the All-Union Scientific Research Institute of Medical and Medico-Technical Information, USSR

The experiment was based on the decision that wide-scale implementation of preventive measures required an appropriate system of CE.

The experiment aimed to enable PHC personnel to put into practice the concept of an integrated approach to prevention of major non-communicable diseases (NCD) through progressive removal of selected common risk factors.

For planning purposes an "epidemiology group" was established, consisting of members of scientific and research institutes as collaborators with the scientific research institute of medical and medico-technical information (responsible for the experiment). Their task was to design content and methods for the experimental programme and how it was to be implemented. The base line data consisted of a survey of the lifestyle of the population and responses to a questionnaire by PHC personnel.

Teaching modules were prepared for managerial staff of out-patient health facilities (policlinics) and PHC personnel. A 3-day "pilot study" was organized to validate the experimental modules for content, facilities, effectiveness, cost.

Participants were managerial staff from all polyclinics in the selected regions in the town, health district physicians (as instructors), PHC doctors in internal medicine, nurses, and physician assistants.

Forms of educational activities were a 1-day seminar, at regional level for managerial staff and selected instructors. At the local level CE was mostly conducted as in-service training.

The educational methods were lectures, workshops, seminars, briefings, analyses of actual situations, discussions, use of teaching modules with subsequent discussions.

The main topics were detection/control/correction and preventive measures concerning: arterial hypertention, smoking , overweight, physical inactivity.

Teachers participating in the experiment were programme developers, trained instructors from districts, locally trained staff.

After selection of indicators and criteria an evaluation was to assess new knowledge, use of new knowledge and skills in practice and quality of practice.

3.9 Development of a new pattern of CE for PHC personnel using video and computer technology (case study by the Working Group of the Andrija Stampar School of Public Health, Yugoslavia

The main reason for wishing to develop a new type of CE was based on evidence of the inadequacy of existing CE. Subject matter did not meet practice requirements, educational methods relied on passive learning, andhealth personnel were not sufficiently stimulated to take part in CE.

The major aim was, therefore, to improve the quality of PHC as a specific discipline. CE, using electronic technology, was to provide continuity and regularity of structured information at the place of work, activate involvement of participants, sharing experiences and gathering information, assessing attitudes and working methods with experts, obtaining fresh and unbiased information. An immediate objective was to form a centre for the production and distribution of educational material for CE (Educational Multimedia Centre - EMC).

Planning was based on bilateral scientific and technical cooperation

between two countries. For implementation a joint international committee was formed.

EMC produced a monthly videotape (30 minutes), compact discs with educational programmes supported by computer four times a year; annually two to four audio tapes on particular topics. These materials were used by a network of health and medical centres and 240 educational units, each with two coordinators and nine active units with play-back and computer equipment. These materials were used at meetings, and users paid a contribution for this service.

The participants were doctors and others in PHC settings of the network.

Evaluation of the educational programmes was made by feed-back built into the training materials; formative evaluation was made during the production of the training material. The system as a whole was evaluated by questionnaires, initially orientated to process. Outcome was to be undertaken at a later stage. Evaluation of acceptance of the system in the initial stage of development was positive.

3.10 Distance learning for doctors in rural areas (case study by the Wellcome Tropical Institute, UK)

A 5-year project was initiated by a European tropical institute which aimed to assist tropical countries to establish continuing education for rural medical officers through distance learning. The strategy, planning, implementation and evaluation methods merit consideration within the European context.

The aim was that active CE would provide rural doctors with competence to plan, implement and evaluate clinical and PHC improvements in their district.

The strategy emphasised collaboration with local authorities in the planning of a CE system for the use of distance learning and participation of local educators in the establishment of needs for CE, planning and preparation of distance learning materials, as well as their use and evaluation.

The tactics included the training of selected educators in organizational and educational methods, holding of workshops for briefing local organizers and participants and for debriefing of organizers and participants.

The materials were designed for self-study supported by supervised practice and the completion of an epidemiological study project.

Evaluation of the materials and the system of distance learning was an integral part of the programme.

4. Discussion of key issues in continuing education

The discussion based itself on the recognition that continuing education could no longer be regarded as merely a means for maintaining the quality of existing practises of health care but that continuing education should be an essential element in the process of change. In particular, this

process of change should be aimed at change in attitudes, skills and methods of collaborative practice required for successful primary health care in the context of Health for All by the Year 2000.

The review of the substantially enlarged series of country reports on the present organization of continuing education and the review of the ten case studies made it clear that a number of aspects should be explored in greater detail.

4.1 The role of continuing education in primary health care

The case studies indicated that primary health care would not be practised effectively, unless a number of conditions were met. These were identified as:

(i) the "political will" of countries to implement primary health care as a means towards health for all should be translated into supportive planning and budgeting for CE by the authorities who are charged with the responsibility for organizing primary health care as a part of their country's health care system;

(ii) the interests and intellectual resources of organizations and institutions, which are involved in basic, postbasic and continuing education and training of health professionals, need to be focused on the special requirements of education for primary health care;

(iii) the attitudes and skills of all who are to provide education for primary health care need to be atuned to this quite specific task;

(iv) the attitudes and skills of both present and future health professionals need to be directed towards the special tasks involved in either providing primary health care or in collaborating with primary health care as members of other components of the country's health care system.

The case studies assisted the discussion to identify how continuing education, in one form or another, constituted an essential means for facilitating change - change in attitudes and change in skills, as well as change in knowledge and understanding. Continuing education should thus be acknowledged as a potent and, indeed, essential agent for change in the movement towards health for all through a growing application of primary health care. In addition, continuing education should be acknowledged as a key factor in maintaining and enhancing the commitment and skills of the professions who provide primary health care and of all those in other sections of the health care system who should support primary health care.

A logical consequence is that continuing education has to be accepted as an integral and ongoing element within the overall system of the health care service at central, regional, district and local levels. The country reports on continuing education of health personnel illustrated clearly that the organization of continuing education would differ from country to country according to the characteristics of their health care system. However, in all countries, continuing education would need to be provided with appropriate resources in terms of personnel, material facilities and finance.

4.2 Adapting to change and participating in change

The concepts, aims and practical implications of Health for All and Primary Health Care were still relatively unfamiliar to many policy makers, health service administrators, officers and officials of institutions and organizations, facilitators of continuing education, and health professionals in general. Yet, the desired changes from past attitudes and approaches to good health and ill health would expect all these politicians, administrators, officials and health professionals to adapt to these changes and, indeed, to participate in implementing related further changes. The competences for adapting to change would include the skills of critically evaluating the factors involved in the need for change and in the consequent nature of the change, the will and skill of identifying what needs to be learned, how to acquire this learning and how to apply it in actual practice, as well as how to evaluate one's own performance with a view towards further improvement.

Participation in change would encompass a wide range of roles, from the role of an initiator of something new, to that of a facilitator of a change, and someone who evaluates the potential consequences of a change and suggests modifications in the process of change or in the change itself. The competences needed by such change agents would range from skills of critical analysis and synthesis to creative problem solving and interpersonal - communication skills.

The case studies supported the discussion in the recognition that the competences needed for adapting to change and for participating in change could only be acquired through active learning, learning through practical experience and active participation in the identification of what needs to be learned, in planning how learning should be implemented and in evaluating the success or effectiveness of the learning.

This approach to learning within the health professions was not seen as unique to continuing education but also as a key element in undergraduate or basic education to equip future health professionals with the essential attitudes and competences for adapting to change and for participating in change. In this way, continuing education was seen as an essential aspect of life-long learning. The emphasis on personal responsibility for learning and on active participation in education were also seen as necessary and effective means towards personal growth and career development.

4.3 Evaluation and a systems approach

The case studies underlined the importance of evaluation as an integral aspect of continuing education for change. The studies also identified many difficulties of both process and outcome evaluation. It became clear that continuing education could not be evaluated in isolation but only in the context of identified needs, specified change to meet the needs, and a clear understanding of the role of the educational intervention in the wider context of health service strategy and tactics, as well as other implications of environmental factors, such as the attitudes of the community, any legal constraints and available resources. Continuing education would thus be seen as a means towards a well defined end, an end that was determined by specific needs of the community and/or the health care system, and/or the health professionals themselves. It should thus be possible to specify the need for change, the nature of the change, how and with what means the change was to be implemented and, therefore, the modification of attitudes and the

acquisition of knowledge, understanding and skills to be achieved through educational activities. It was thought important at this stage to emphasize that such education should not be episodal in response to intermittantly identified needs. To the contrary, continuing education should be an ongoing programme as part of a planned strategy of improvement in primary health care and other aspects of the health services, as well as the needs of individual health professionals.

Once the objectives of continuing education had been defined as discussed above, evaluation could be planned as a part of the overall design of the educational process. Evaluation could then be planned to serve the health professionals who were participating in the education to provide them with feedback on their educational achievements, as well as on the longer term effect in relation to the community. Evaluation could be aimed to assist planners and facilitators of educational programmes to consider further improvements in the relevance, acceptability, effectiveness and efficiency of their interventions. Evaluation could also be planned to assist the authorities by investigating the cost effectiveness of the educational programme in the context of other factors that affect the outcome of change.

Even if the above conditions were fully met, evaluation could encounter a variety of uncontrolled factors, and it was acknowledged that outcome evaluation must frequently extend over a number of years and could be costly. Because evaluation was an essential element in the planning and implementation of change and should, therefore, be included in the budget for change, it was thought important that continuing research into process and outcome evaluation should be encouraged and supported in Member States with a means for the interchange of information and experience.

4.4 Interprofessional team building

The case studies supported the view, expressed at the WHO Meeting on Study on Systems and Organization of Continuing Education at Country Level (Copenhagen, April 1986), that team building might best be achieved and subsequently reinforced by team members participating in CE activities at their place of work. Discussion identified that a preferred approach was to provide the team with opportunities to consult with each other towards solving actual problems. Such problems might relate to individual patients or to the community.

However, the educational value of such consultations or case conferences would be largely dependent on sensitive and skilled leadership, not only to assist team members to come to appreciate each others' contributions and points of view, but also to help members in identifying new knowledge and understanding to be acquired and new skills to be practised. These considerations underlined the importance of providing facilities for team leaders and other tutors to become skilled and sensitive in the process of team building and interprofessional continuing education.

4.5 Obstacles to change through continuing education

It was thought desirable to consider the factors that appeared to inhibit or hinder successful implementation of CE for change. This diagnostic process might then suggest appropriate approaches towards the removal or amelioration of such adverse factors. The case studies made it clear that the success of CE might be impeded by problems at a number of levels:

authorities, institutions or organizations, facilitators of education and participants in education, as well as the community with its attitudes and expectations. A limited number of examples are cited here to illustrate the value of the case studies in drawing attention to problems and potential solutions.

Policy makers might be constrained by short-term priorities. They might also lack information for an appreciation of the nature of major needs that called for strategies requiring an extended period of time for their implementation. Similarily, administrators in central or peripheral authorities might not be aware of the essential need for managerial skills for local allocation of limited resources and for personnel management. In both examples, lack of awareness or appreciation, due to lack of access to appropriate information, might seriously inhibit policy making, overall planning and allocation of adequate resources - all in relation to CE. Those who decided policy and provided the financial means for its implementation also needed information for assessing the cost effectiveness of their decisions. An acceptable and practicable network of communication between the various participants in the health care system and its CE programmes would, therefore, appear to be an important prerequisite for successful change through CE.

Institutions and organizations might, by the very nature of their constitution, see their educational interests in the propagation of their own discipline or specialty. It would be unrealistic to expect otherwise, until such institutions and organizations were in a position where they could see themselves as integral partners in the identification of needs, planning of related changes and then the specification of appropriate educational objectives. They might also look for legislative support and assurance of adequate resources, in order to play their part in an overall system of continuing education.

Facilitators of continuing education, teachers and tutors, might need opportunities to familiarize themselves with the working conditions, points of view, as well as levels of knowledge and skills of those health professionals whom they were to help through continuing education. Collaboration between the teachers or tutors and the participants in agreeing on the objectives and methods of continuing education programmes would do much to ensure that the learning would be relevant, acceptable and effective.

The health professionals, who are expected to implement or support primary health care, were the largest group for whom continuing education for change had to be provided. The discussion devoted, therefore, specific attention to the problems of this group. Intrinsic problems were thought to centre on motivation, perceived or real lack of time for CE, resistance to change due to fear of loss of status, reputation or power, resistance to assuming the traditional, passive role of students, resistance to mandatory participation in CE, and possibly even adverse attitudes towards primary health care. Though a range of specific proposals were considered for resolving these problems, the overriding conclusion was that active participation in educational planning, implementation and evaluation was best suited to overcome most if not all these problems.

An impressive list of extrinsic factors was considered during the discussion. These ranged from geographical or professional isolation to lack

of incentive - including lack of financial support and lack of recognition for participation in CE, to lack of access or irregularity of access to CE, and the variable quality of teachers, as well as conflict between preferred learning style and presented teaching style. While some of these obstacles to successful participation in CE would call for an organizational or technological solution, as, for example, distance learning for geographically scattered practitioners, other problems were more directly related to teacher training and further exploration of appropriate methodology through educational research.

Two aspects were raised most frequently during the discussion as important for successful continuing education:

(i) legislative and policy support for the recognition, organization and financial infrastructure of continuing education;

(ii) active participation based on competence in self-directed learning by all concerned with continuing education.

5. Conclusions

The initial surveys and case studies carried out in 1985-1987 by the WHO European Regional Office in selected European countries within the framework of the "Study on systems and organization of continuing education at country level" outlined the current situation and trends in CE activities for health personnel in the European Region.

The case studies represented a fertile source of creative approaches to the challenges of CE. They ranged from collaboration between general practitioners and hospital staff for the improvement of patient care, to collaboration between institutes and country officials for the creation of CE systems and implementation of CE programmes. Some studies illustrated methods for enhancing leadership or management in PHC. Other studies reported methods in CE for change in, for example, care of the elderly or prevention of non-communicable diseases. Yet others are concerned with improving PHC through enhanced teamwork and communication skills. While there was an example of experimentation with audiotape, video tape, compact discs and computers for gathering and imparting new information within a network of centres, another study reported a carefully planned and implemented long-term programme that spanned twenty-four years.

The importance of the new role of CE as a major agent for change emerged repeatedly in the review of the country reports and case studies, as well as in the discussions.

Changes in health care policy, organization and methods make it essential for CE to assist in developing the attitudes and skills needed for adapting to change and for participating in change itself - not only for health professionals, but also for those who are responsible for policy making and implementation, as well as those who are involved in organizing CE.

CE must achieve recognition of its important and integral role within the health care system, so that its input can be appropriately planned, securely funded and realistically evaluated.

CE systems and programmes need to be aware of the numerous obstacles to change that were identified in the country reports, case studies and the discussions. Many of these obstacles can be overcome by ensuring active participation in the processes of CE by all who are involved in CE, especially those who are the learners.

Although the case studies illustrated growing participation by a wide range of professionals, the country reports indicated that doctors continued to be the single largest group of participants in CE.

A clear trend towards greater emphasis on PHC and on team training could be identified. While several case studies provided imaginative examples of sensitive interprofessional CE, this task remained open to further experimentation and development.

Although many case studies illustrated effective use of PHC personnel and, indeed, of participants as teachers, the country reports indicated a continuing dominance of academics and specialists as teachers and a persistent emphasis on acquisition of knowledge, rather than on attitudes and skills.

6. Recommendations

In view of the acceptance by Member States of the philosophy and requirements emerging from new health policies based on HFA regional and national strategies, it was considered important that steps should be taken to ensure that the necessary attitudes, skills and competences could be acquired by health professionals responsible for the implementation of these policies. It was thought that governments would wish to ensure that CE would concentrate on primary health care, including health promotion and interprofessional team work; that CE would be used to foster attitudes and skills for adapting to change and for actively participating in change; and that CE would be accorded an integral role in the health care system, as well as adequate facilities and financial resources.

It was also thought desirable that providers and users of CE should concentrate their attention on self-directed learning through problem-based learning, and on communication skills and multiprofessional collaboration in teams, especially in the context of PHC. It was considered equally important that providers and users of CE should engage in active communication with each other, with the health services and with the community in planning and implementing CE programmes.

The Workshop appreciated the initiative and action taken by the Regional Office in relation to continuing education of health personnel as part of a long-term HMD programme. It was thought that Member States would be greatly assisted if WHO were able to ensure that CE were integrated as a substantial part in the European Action Plan on health personnel development, supportive of health for all; if WHO could assist in promoting research and interchange of information in evaluation and in the acquisition of attitudes and skills through interprofessional training, for multiprofessional teamwork, particularly in PHC.

LIST OF WORKING PAPERS AND BACKGROUND MATERIAL

Country reports (surveys) on continuing education of health personnel

ICP/HMD 120/6	System and organization of continuing education of health personnel in the People's Republic of Bulgaria, by Professor J.G. Jordanov
ICP/HMD 120/7	Continuing education of health personnel in Czechoslovakia: Initial survey, by Professor J. Vysohlid
ICP/HMD 120/8	Existing situation and trends in Denmark concerning further education of employees in the primary health care service, by Dr M.K. Kjaergaard Hansen
ICP/HMD 120/9	The present state of continuing education in primary health care personnel in France (early 1986), by Dr P. Klotz
ICP/HMD 120/10	Continuing education of primary health care personnel in Finland, by Professor M. Isokoski
ICP/HMD 120/11	Initial survey on continuing education programmes for primary health care teams in the German Democratic Republic, by Professor K. Spies
ICP/HMD 120/12	Continuing medical education in Greece - Existing situation and tendencies, by Dr V.A. Haralambides
ICP/HMD 120/13	Health, health care and its institutional basis. Health and health care in Hungary, by Professor I. Forgacs
ICP/HMD 120/14	The present situation and current tendencies in the system for the continuing education of Italian health professionals, by Professor B. Paccagnella
ICP/HMD 120/15	Continuing education for general practitioners in the Netherlands, by Dr J.A. Schraag
ICP/HMD 120/16	Polish system of postgraduate education with focus on continuing medical education for primary health care, by Professor A. Wojtczak
ICP/HMD 120/17	Existing situation and trends in continuing education systems and programmes for primary health care personnel: a Spanish survey, by Professor Margarita Baron Maldonado
ICP/HMD 120/18	Study on the current situation and trends in continuing education - Catalonia's report, Spain, by Professor A. Oriol-Bosch

ICP/HMD 120/19 Continuing education within primary health care in Sweden, by Mr B. Eklundh

ICP/HMD 120/20 Continuing education in Turkey, by Dr C. Ozcan

ICP/HMD 120/21 Continuing education programmes for primary health care teams. A survey of existing provision in the United Kingdom, by Dr A.M. Gray

ICP/HMD 120/22 Continuing education of personnel in primary health care in the USSR - Review, by Dr F. Vartanian

ICP/HMD 120/23 Initial survey on the state and development of continuing education for primary health care in Yugoslavia, by the Working Group of the Andrija Stampar School of Public Health (Zagreb)

ICP/HMD 120/23A Continuous training: Portuguese situation report by Dr J.P. Neves Nunes dos Santos

ICP/HMD 120/23B Continuing education in Israel by Drs H.S. Kedar and S. Sherwin

ICP/HMD 120/24 Short review of country reports, by Professor J. Vysohlid

Reports of the case studies on continuing education of health personnel

ICP/HMD 120/25 Continuing education in local hospital of Burgundy: a French case study on continuing education of primary health care teams, by Dr P. Klotz

ICP/HMD 120/26 Task oriented continuing education of health personnel responsible for the HFA policy at county and town level - Case study from Hungary, by Professor I. Forgacs

ICP/HMD 120/27 System and organization of continuing education of the health personnel in Italy - Case study, by Professor B. Paccagnella

ICP/HMD 120/28 Catalonia's case study on continuing education of health personnel, by Drs J.M. Martinez-Carretero, Maria Nolla-Domenjo and Professor A. Oriol-Bosch

ICP/HMD 120/29 Continuing education on the role of primary health care in the care of the elderly - Case study from Sweden, by Mr B. Eklundh, Mr J. Hultin, Dr B. Mattson and Dr Margerata Troein

ICP/HMD 120/30 Study on systems and organization of continuing education at country level - Distance learning for doctors in tropical countries, by the Wellcome Tropical Institute (London), UK

ICP/HMD 120/31 Continuing education in primary health care in England, by *Dr D.M.D. Lambert*

ICP/HMD 120/32 Case study on continuing medical education, by the Central Institute for Advanced Medical Studies (Moscow), USSR

ICP/HMD 120/33 Elaboration of a system for the intensive mastery of fresh knowledge at primary health care establishments: experimental study, by the All-Union Scientific Research Institute of Medical and Medico-Technical Information (Moscow), USSR

ICP/HMD 120/34 Continuing education for primary health care using video and computerized technologies: a case study of development of a new system in SR Croatia, Yugoslavia, by the Working Group of the Andrija Stampar School of Public Health (Zagreb)

Background material

ICP/HMD 103m02(S) Consultation on Multiprofessional and Continuing Education, Copenhagen, 1984. Summary report

ICP/HMD 103m02/7 Discussion paper on continuing education, by Professor P. Hamilton and Ms J. Spratley

ICP/HMD 119 Study on systems and organization of continuing education at country level: report on a WHO meeting, Copenhagen, 1986

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